PHYSICIAN'S REFERRAL

COMMUNITY NURSING SERVICE

WASATCH COUNTY HOME HEALTH AGENCY
25 North Main Street
Heber City, Utah 84032

Hospital _____ Room _____

Physician _____

Agency _____

Patient's Name _____

Address _____

Age _____

Date of Referral _____

A. Report of Physician:

Diagnosis and Prognosis is (including pertinent information given to patient and/or family on diagnosis and prognosis).

B. Orders:

(Including medication, treatment, diet, activity and specific techniques which may be taught). MEDICATIONS TO BE ADMINISTERED BY NURSE MUST BE IN THE HOME.

Diet _____

B.R.P. Yes _____ No _____

Estimate of hospital days saved _____

Up ad. lib. Yes _____ No _____

Enema P.R.N. Yes _____ No _____

Type _____

Date visits start _____

Request telephone reply from nurse
Yes _____ No _____

CERTIFICATION BY PHYSICIAN:

Patient is confined to home and needs intermittent skilled nursing care or therapy. A treatment plan is established and will be reviewed periodically (at least every (2) two months). If patient qualifies under Medicare Part A, services will treat a condition for which patient was hospitalized.

_____
Physician's Signature

C. Report of Hospital Nurse:
(Observations, demonstrations, instructions and/or teaching given).

D. Report of Nursing Visit:

1. Patient's condition, care and instruction given:

2. Home and Family Situation:

3. Plans (including frequency of visits):

4. Date of visit _____ _____ R.N.
Signature

1 copy return to physician
1 copy retain in family folder

(If referral agency is a hospital, referral should be made in triplicate with third copy returned to hospital).

1-15-69